

Return Application With
Check Payable To:
Treasurer – State of NH
Renewal Fee: \$250

State of New Hampshire
Board of Pharmacy
121 South Fruit Street
Concord, NH 03301-2412
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

Board Use Only

RENEWAL APPLICATION - JULY 1, 2014 TO JUNE 30, 2015 LICENSING PERIOD

**MANUFACTURER, WHOLESALE, DISTRIBUTOR, OR BROKER OF PRESCRIPTION DRUGS AND/OR DEVICES
FOR SALE OF PRODUCTS IN NEW HAMPSHIRE AT WHOLESALE**

FOR RENEWALS ONLY – THIS FORM WILL NOT BE ACCEPTED FROM NEW APPLICANTS

Location Of Facility Where Actual Manufacturing / Distribution Takes Place (If Broker Only, Business Mailing Address):		
NH License #: _____		
Company Name: _____		
Street Address: _____		
City / State / Zip: _____		
Parent Company (If none, write 'None'):		State Of Incorporation (If Corp.):
Nature Of Business (Check ALL That Apply): <input type="checkbox"/> Manufacturer* <i>If checked, is your company currently registered/licensed by the FDA?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Wholesaler/Distributor <input type="checkbox"/> Broker <input type="checkbox"/> Other (Attach Explanation)		Doing Business As: <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> LLC
Telephone:		E-Mail Address:
DEA Number (If Shipping Controlled Drugs):		State Controlled Substance Lic. #, If Applicable:
Name Of Owner(s): Indicate Individual, Partners, Etc. (If Corporation, Show Title Of Officers). Attach Additional Sheet If Necessary.		
Name	Address	Title
Name	Address	Title
Is the above referenced company (physical location) licensed by the board of pharmacy in the state of location? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Since your last New Hampshire renewal was submitted, has a registration or licensure granted to the above referenced company by any state or federal agency been suspended, revoked, or otherwise disciplined? <input type="checkbox"/> Yes * <input type="checkbox"/> No * (If "Yes", attach a detailed explanation, along with copy of legal documentation of discipline)		
Provide the name, title, & business mailing address of the person to whom the permit, future renewal applications, and all Board communications should be directed:		
Name:	Title:	Tel. #:
E-Mail Address:		
Mailing Address:		

APPLICATION CONTINUED ON OTHER SIDE ↵

If shipping controlled drugs, provide the name, address, telephone & fax # of the person to whom communication regarding controlled substance distribution records may be directed:

Name: Telephone #: Fax #: E-Mail:

Business Mailing Address:

Which of the following entities do you sell / ship to?

- ☐ Retail Pharmacies ☐ Hospital Pharmacies ☐ Physicians ☐ Dentists
☐ Veterinarians ☐ Other Wholesalers ☐ Other _____

Categories of product being sold / shipped into New Hampshire at wholesale?

- ☐ Controlled Substances ☐ Human Prescription Drugs ☐ Veterinary Prescription Drugs
☐ Prescription Devices(At Wholesale) ☐ Medical Gases (At Wholesale) ☐ Other _____

Attachments & Declaration / Signature By Company Representative:

I affirm that I am the person authorized to sign this application for licensure and affirm that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the registration herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State.

ATTACHMENTS REQUIRED:

(ALL REQUIRED ATTACHMENTS MUST BE SUBMITTED OR YOUR APPLICATION WILL NOT BE PROCESSED)

I confirm that the following attachments have been attached to this renewal form:

- ☐ 1. A copy of the facility's current license/registration issued by the Board of Pharmacy or other state regulatory agency where the facility is located (home state);
- ☐ 2. A copy of the facility's current Federal DEA Registration Certificate if shipping controlled drugs;
- ☐ 3. A copy of the facility's most recent inspection report issued by either the FDA, NABP / VAWD Accreditation, or State Board of Pharmacy where the pharmacy is located (home state).

Signature: _____ Title: _____ Date: _____

INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT REQUIRED ATTACHMENTS WILL NOT BE ACCEPTED.

DO NOT LEAVE ANY BLANK SPACES – IF NOT APPLICABLE, WRITE N/A & THE REASON IT DOES NOT APPLY.

**ANY SUBSEQUENT CHANGES TO THE INFORMATION ON THIS FORM
MUST BE REPORTED TO THE BOARD IN WRITING WITHIN 15 DAYS.**